STATE OF MICHIGAN
IN THE SUPREME COURT

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Cross-Appellants,

vs.

JOSEPH R. CUSTER, M.D.,

Defendant/Cross-Appellee,

and

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Cross-Appellants,

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant/Cross-Appellee.

Supreme Court
No. 124994-95

Court of Appeals
No. 239868

Washtenaw Circuit Court
No. 99-5364-NH
Hon. Timothy P. Connors

CASE CONSOLIDATED AND JOINED WITH:
Court of Appeals
No. 239869

Court of Claims
No. 99-17432-CM

124994
(53)

12/30

24888

PLAINTIFFS/ CROSS APPELLANTS' APPLICATION FOR LEAVE TO APPEAL

NOTICE OF HEARING

PROOF OF SERVICE

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NOTICE OF HEARING

PLEASE TAKE NOTICE that the Plaintiffs/ Cross-Appellants Cross Application for Leave

to Appeal will be brought on for hearing on Tuesday, December 30, 2003.

NEMIER, TOLARI, LANDRY,
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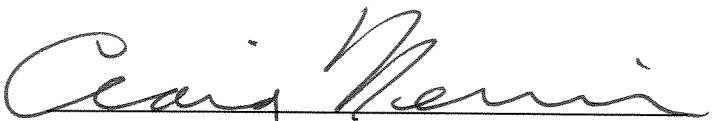
By: 

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Dated: December 8, 2003

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STATEMENT OF APPELLATE JURISDICTION

These joined actions for medical malpractice against the University of Michigan Medical Center (Court of Claims action) and the action against the hospital's doctor (Washtenaw Circuit action) were dismissed by a February 7, 2002 order (entered on the court's docket sheet on February 12, 2002). The Claim of Appeal in both actions was filed February 27, 2002, and within 21 days of both the dating of the order and its entry on the docket sheet. By order dated April 23, 2002 the Court of Appeals consolidated the appeals. On October 21, 2003 the Court of Appeals issued its opinion. On November 12, 2003 the defendants Hospital and Doctor filed their application with the Supreme Court and noticed it for hearing for December 9, 2003. This Cross-Application is timely under MCR 7.302(D)(2), and this Court can exercise jurisdiction under MCR 7.301(A)(2).

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OPINIONS AND ORDERS BEING APPEALED FROM AND RELIEF SOUGHT

Plaintiffs Johanna Woodard and Steven Woodard, Individually, and Johanna Woodard as Next Friend of Austin D. Woodard, a Minor seek leave to appeal from a portion of the Michigan Court of Appeals decision dated October 21, 2003. Attached as Exhibit 1 is the February 7, 2002 Opinion and Order from the Trial Court granting defendants' motion to disqualify Plaintiffs' expert. Attached as Exhibit 2 is the October 21, 2003 Court of Appeals Opinion. Plaintiffs/Cross Appellants request this Court to grant their Application for Leave and reinstate plaintiffs' qualified expert Dr. Casamassima and/or otherwise give full consideration to the relief requested.

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STATEMENT OF NEED FOR SUPREME COURT REVIEW

This court should review the issue of whether plaintiffs' experts in a malpractice case should match up every sub-speciality of defendants or defendants' staff physicians. This case is particularly important since Court of Appeals did not follow the ruling in their own case of Tate v Detroit Receiving Hospital, 249 Mich App 212 (2002).

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STATEMENT OF QUESTIONS PRESENTED

I. **WHERE PLAINTIFFS' EXPERT IS BOARD CERTIFIED IN PEDIATRIC MEDICINE AND THE DEFENDANT HOSPITAL'S DOCTORS IN THE PEDIATRIC UNIT WERE ALSO BOARD CERTIFIED IN PEDIATRIC MEDICINE WITH A CLAIMED SUBSPECIALTY, AND THE INFANT PLAINTIFF WAS INJURED DURING PEDIATRIC PROCEDURES, DID THE COURT OF APPEALS ERR IN UPHOLDING THE TRIAL COURT'S STRIKING PLAINTIFFS' EXPERT AND DISMISSING THE SUITS FOR LACK OF AN EXACT MATCH TO THE REMAINING DEFENDANT DOCTOR'S SUBSPECIALTY?**

Plaintiffs/Appellants say:	"Yes"
Defendants/Appellees say:	"No"
Trial Court say:	"No"
Court of Appeals says:	
Judge Talbot	"No"
Judge Meter	"No"
Judge Borrello	"Yes"

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STATEMENT OF FACTS

Overview

These joined cases arise out of the occurrence of two broken legs to a newborn during hospitalization for a breathing problem. The pending claims against the hospital and attending physician/director of the pediatric intensive care unit sound in malpractice for use of improper force while performing pediatric procedures (or maneuvers) which caused two bilateral femur fractures. The fracture of the left leg was into the growth plate and as a result the infant now has a deformed and shorter left leg which will require several surgeries. The case was dismissed because the trial judge determined that plaintiffs' expert, albeit board certified in pediatric medicine, did not match the **exact subspecialties** of the remaining named defendant physician (Ex I). Although the Court of Appeals reinstated the case on the issue of r*es ipsa loquitur* the court did not reverse the trial court's ruling on the issue of matching subspecialties.

Underlying Facts

Austin Woodard, (born January 15, 1997), 15 days old, presented to the University of Michigan Hospital on January 30, 1997 with suspected respiratory syncytial virus (RSV). Earlier that day, Austin was seen by his pediatrician, Dr. John Kennedy, who recommended Austin be transported via EMS to the University of Michigan Hospital because of his breathing difficulties. **(Ex A, Dr Kennedy records)**.[1] The total hospitalization for this problem was from January 30, 1997 through February 28, 1997. However, during Austin's first 12 days of hospitalization (from January 30 through February 10, 1997) while a patient in the Pediatric Intensive Care Unit (PICU),

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[1]In the interests of paper reduction, (aside from the attached Exhibits 1 and 2), the instant case's trial opinion and the appeal decision) the referenced alphabetical exhibits are attached to Plaintiffs' Reply to Defendants' Application for Leave to the Supreme Court.

he sustained two broken legs; both discovered upon transfer to another unit. Defendant Dr. Joseph Custer M.D., the hospital's director of the PICU, was responsible for the PICU staff. **(Ex L, Dr. Custer, pp 3, 5).**

During the 12 days in the PICU, Austin underwent several medical procedures, including the following: On January 30, 1997, Austin was intubated to provide respiratory assistance. **(Ex L, Dr. Custer, pp 15-16).** He remained intubated through February 9, 1997, was sedated, and received feedings through a feeding tube during that time. On January 31, an arterial line was placed in his right groin. On February 1, he had a blood transfusion, supposedly to increase his red blood cells. On February 2, a central venous catheter was placed in his left groin area. On February 6, the right arterial line was removed. **(Ex P-Dr. Casamassima dep, pp 48-52).**

On February 7, the left central venous catheter was removed. **(Ex L, Custer, pp 15-16).** It was bent at the site and leaking clear fluid. **(Ex B, 2/7/97 critical care flowsheet)**. The hospital records also show on February 9 (hospital day number 11), that Austin was becoming extremely agitated; even though he was significantly sedated he awakened easily and had long drawn out crying spells.

As stated above, during his admission in the PICU, Austin was intubated from January 30 to February 9, 1997 and required ventilation to assist his breathing. He ate from a feeding tube. During this time, Austin's parents were unable to hold and/or feed him. Austin's parents were kept out of Austin's room during procedures, such as intubation and line insertions, and could not stay in the room overnight with him. **(Ex C, J. Woodard Dep, pp 18-19, 23, 26)**. Austin was on a feeding tube until February 9, 1997, so his mother was not able to nurse Austin either. **(Ex C, J. Woodard Dep, p 11)**. Austin's mother, Johanna Woodard, testified that she had to call on someone

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from the hospital staff to get into the PICU area where she could see Austin. **(Ex C, J. Woodard, pp 18, 26)**. Furthermore, Mrs. Woodard was kept from seeing her infant son on one particular occasion; she was told the hospital personnel were having difficulty inserting a line into Austin so she could not see him. **(Ex C, J. Woodard Dep, pp 26-31)**. Another infant patient, Brianna Reynolds, was sharing the room with Austin at this time. Brianna's mother, Kendra Reynolds, later told Mrs. Woodard that she saw the hospital personnel having trouble with Austin's line insertion, and saw a lot of blood before the hospital personnel asked Mrs. Reynolds to leave the room. **(Ex D, J. Woodard Dep Trns, pp.38-40)**.

Kendra Reynolds testified as to the incident in the PICU. While visiting her daughter, several medical personnel began to perform what Ms. Reynolds recognized as a line insertion on Austin, and Austin began bleeding profusely. The medical personnel became panicky in their demeanor, and quickly thereafter asked Ms. Reynolds to leave the room. **(Ex D, Reynolds Dep, pp 9-13)**. In spite of what appears to be un-controverted testimony, defendants never made any notations in the chart concerning this very unusual event.

On February 10 (hospital day number 12), Austin was to be transferred from the PICU to the general hospital floor. The February 10, 1997, 11:30 a.m. nursing transfer note reflects: "Becomes very agitated, and turns red in the face, cries." **(Ex E, 2/10/97 nursing note).** Leg swelling was not noted. However, at 1:00 p.m., just before Austin was transferred from the PICU to the general floor on February 10, the same nurse noted in a "transfer note addendum" that: "**Leg greatly swollen due to CVP line pulled a few days ago,** also infant had both legs pulled up under him impeding venous return." **(Ex E, 2/10/97 nursing note)**. In addition it is undisputed that the nursing flow sheet record for February 10, 1997 indicated that the left leg was edematous and purple.

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Also, undisputed on February 10, 1997, a third year medical student noted that: "Left leg edema due to venous lymphatic stasis." Further, after the catheter was pulled, the infant slept with his knees drawn up. **(Ex L, Custer, pp 27-28).**

By February 11, Austin's left leg was still swollen and was tender to touch. **(Ex L, Custer, p 30).** Although deep vein thrombosis (DVT) was suspected, apparently someone believed something else was occurring, and Austin was sent for an x-ray. **(Ex L, Custer, p 31).** The radiologist reported that there was a minimally displaced comminuted fracture involving a left distal femur, possibly extending into the growth plate. **(Ex F, 2/11/97 radiologist report)**. Following this, Dr. Randall Loder, a University of Michigan pediatric orthopedic surgeon (a children's bone specialist), was consulted the evening of February 11. He felt a fracture was likely, although there could be an "occult infection"[2] and they would follow up on repeat x-rays. **(Ex G, 2/12/97 consultation report).**

A full skeletal survey was performed on February 13, revealing both left and right femur fractures, with the left extending into the growth plate. **(Ex H, 2/13/97 radiologist report)**. In the follow up consult of February 13, Dr. Loder confirmed there was a fracture of the left femur, as well as what he felt was a slightly older fracture on the right. **(Ex I, Loder dep, pp12-16)**.

After reviewing the films with the radiologist again, Dr. Loder opined that the fracture was traumatic and not pathologic. **(Ex I, 2/13/97 Loder consultation report)**. Thus, Dr. Loder ruled out

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[2]"Occult" means hidden or concealed. See Attorney's Dictionary of Medicine, Vol 3, pp 0-12 (1984). Thus the doctor had a concern of a bone infection. Osteomyelitis is an infection of bone. Attorneys' Textbook of Medicine, 3rd Ed, p 2-76 (1983).

osteomyelitis as a cause of the fractures.[3]

On May 22, 1997, Austin saw University of Michigan geneticist, Dr. Jeffrey Innis, who determined that brittle bone disease was not the cause of Austin's fractures. **(Ex K, 5/22/97 Innis report)**.

There is no notation in the University of Michigan Hospital records which suggest any indication that Austin may have come into the hospital with bilateral fractures. **(Ex L, Custer Dep, p 40)** To the contrary, there are references in the medical records suggesting the fractures occurred during Austin's stay in the PICU. **(Ex L, Custer Dep, pp 40-41).** In particular, the discharge summary for Austin's second inpatient admission (due to seizures he developed) notes, "Orthopedics. He sustained bilateral femur fractures during the last hospitalization." **(Ex M, 3/7/97 discharge summary)**. Also an inpatient note on 3/10/97 indicates the femoral fracture on the left was due to procedure in the ICU. **(Ex N, 3/10/97 in-patient note)**.

Defendant Dr. Custer is board certified in pediatrics, with **certificates** (not bard certification) in the subspecialties of pediatric critical care medicine and neonatology-perinatology. **(Ex L, Custer Dep, p 4).** Austin was officially on Dr. Custer's service, as the director of the PICU at the University of Michigan Hospital, while Austin was a patient in the PICU, i.e. from January 30, 1997 until his transfer to the general floor on February 10, 1997. **(Ex L, Custer Dep, pp 3-4, 66-67)**. Dr. Custer was in contact with Austin Woodard in two ways, (1) as an attending physician, and (2) as the

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[3]In January 2001, Austin was evaluated by a second University of Michigan orthopedic surgeon, Dr. Farley. Dr. Farley is a specialist in leg lengthening procedures and a colleague of Dr. Loder. Dr. Farley considers Dr. Loder to be a good doctor, and was of the opinion that the probability of Dr. Loder missing osteomyelitis if it existed was "very low." **(Ex J, Farley Dep, pp 17-18)**. Dr. Farley examined Austin and found a leg length discrepancy due to the fracture which may require surgery. **(Ex J, Farley Dep, p 6-8)**.

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director of the medical physicians that work in the PICU. **(Ex L, Custer Dep, p.5)**

Contrary to the factual assertions in Defendants' application for leave to appeal, Dr. Custer admitted there was no evidence indicating the fractures occurred before Austin's admission to the hospital's pediatric care unit. **(Ex L, Custer Dep, pp 40-41).** In addition a patient, such as Austin, is sedated and given muscle relaxants; they are anesthetized and have to be moved by nurses to change positions. **(Id p 47).** Following discovery of the two fractures, Dr. Custer contacted Dr. Clyde Owings, head of the University of Michigan Child Protection Unit. **(Ex L, Custer, pp 32-33).** Dr. Owing investigated the possibility of child abuse as a cause of the fractures. He reviewed the x-ray films, talked to the radiology department and other treating physicians, examined Austin, and came to the conclusion that this was not a case of child abuse and therefore did not report it. **(Ex O, Owings Dep, pp 28-29)**. Strangely, in his 19 years doing this work, this is the only case where Dr. Owings did not keep a file/record of his investigation. **(Ex O, Owings Dep, p 37)**.[4]

During discovery, it was made clear to plaintiffs it would be virtually impossible for plaintiffs, or any expert on behalf of plaintiffs for that matter, to point to the specific individual(s) or procedure(s) performed at University of Michigan Hospital which caused Austin Woodard's bilateral femur fractures. Dr. Casamassima, plaintiffs' liability expert, candidly admitted this lack of direct evidence in his discovery deposition in August 2001. **(Ex P, Casamassima Dep, pp 4, 7-8)**. However, Dr. Casamassima outlined several procedures which were performed on Austin during his stay in the PICU which could have caused the fractures, such as positioning during insertion of the

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[4]Not only did they rule out child abuse, the hospital also paid all the medical bills (obviously to mitigate the damages should suit follow), including payment of the follow up treatment right up to the hearing on defendants' motion for summary disposition. **(Ex M, 10-12-01 Trans pp 4-6).** Defendants did not deny paying for those bills. **(Ex M, Trans p 14).**

femoral venous line and/or femoral arterial line, positioning during intubation, or manual hip rotation maneuvers. **(Ex P, Casamassima Dep, pp 10-11)**. None of these procedures would ordinarily have a femoral fracture as a known complication. **(Ex P, Casamassima Dep, pp 70-71)**. Dr. Casamassima has knowledge of the amount of force required to create a fracture, based upon his education and experience as a pediatrician who has dealt with a number of pediatric fractures, both traumatic and pathological. **(Ex P, Casamassima, pp.11-12)**.

Dr. Casamassima is board certified in pediatrics **(Ex P, p 67)**. Contrary to the multiple references in Defendants Application for Leave to Appeal stating Dr. Casamassima was a full time attorney, the facts are that between December 1993 to March 1998 he was the Director of Medical Affairs of the Richmond Children's Center. This is 110-bed facility for developmentally disabled children. During that time he had only clinical patient loads, as well as supervising three other physicians and the pediatric nurse practitioner. **(Ex P, pp 63-64).** Three-quarters of his time at the Richmond Center was clinical patient care and the rest, administrative. As a member of the New York Medical College faculty, which funded the center, he supervised residents under four-week rotations. These were pediatric residents. **(Ex P, pp 65-67).** While subsequently (March 1998), he changed careers and is now a practicing attorney, during the year prior to the underlying incident here (between January 30 and February 10, 1999), Dr. Casamassima devoted a majority of his professional time to the active clinical practice of pediatrics, and as well, was involved in the instruction of students serving their general pediatrics residency rotations through the Richmond Clinic. Previous to this, between September 1986 and May 1991, he was the associate director of the medical genetics subdepartment of the New York Medical College Dept. of Pediatrics. Dr. Casamassima has a subspecialty in genetics.

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However, during the relevant time frame of the year prior to the underlying incident, his work was as the Director of Medical Affairs at the Richmond Children's Center, with his clinical practice confined to the practice of general pediatrics. **(Ex P, pp 63-67).**

RULINGS AND PROCEEDINGS OF THE TRIAL COURT

On October 4, 1999, plaintiffs, Johanna Woodard as Next Friend of Austin D. Woodard, a minor, and Johanna and Steven Woodard, Individually, filed a two count complaint in the Court of Claims against the University of Michigan Medical Center, a state hospital, in the Court of Claims, alleging negligence and/or medical malpractice, and negligent infliction of emotional distress.[5] Plaintiffs' complaint and the affidavit of merit of Dr. Casamassima alleged breach of the standard of care as to the hospital in failing: (1) to properly treat and monitor Austin with the degree of care required so as not to fracture Austin's bones, (2) to properly insert an arterial line so as to subject Austin to a loss of blood requiring a transfusion, (3) to properly monitor Austin after insertion of the femoral line and allowing him to lay on one side for over an hour causing Austin's leg to swell and sustain deep vein thrombosis, and (4) to properly monitor Austin after placement of the arterial lines and femoral venous lines to prevent onset of line sepsis, subsequent bacterial infection, causing Austin to have multiple cerebral infarctions. **(Ex Q, Ct of Claims Complaint & Aff of Merit).**[6]

On October 7, 1999, plaintiffs, Johanna Woodard as Next Friend of Austin D. Woodard, a minor, and Johanna and Steven Woodard, Individually, also filed an action for medical malpractice in the Washtenaw County Circuit Court against the individual University of Michigan Medical

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[5]It was agreed, later, that the emotional distress claims of the parents would be dropped. **(Ex T, Trans 9/14/01, pp 4-5).**

[6]The affidavit was filed January 4, 2000 under MCL 600.2912(d)(3) since defendants failed to timely allow access to the medical records. **(Ex S, Trans 3/31/00, pp 9-12).**

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Center physicians - Dr. Joseph Custer, Michael K. Lipscomb, M.D., Michele M. Nypaver, M.D., and Mona M. Riskalla, M.D., jointly and severally. This complaint, and affidavit of merit by Dr. Casamassima, alleged the same breaches of the standard of care applicable to the physicians as was alleged against the hospital. **(Ex R, Washtenaw Co Complaint & Aff of Merit)**.

On February 10, 2000, the cases were joined pursuant to MCL 600.6421 with Washtenaw County Circuit Court Judge Timothy P. Connors sitting for both cases.

3-31-00 Defendants' First Motion for Summary Disposition

On March 31, 2000, defendants moved for summary disposition pursuant to MCR 2.116(C)(4), (C)(5), and (C)(7), alleging, *inter alia*, that plaintiffs' affidavits of merit were late and not signed by a physician whose specialty matched that of the defendants. The court found that defendant Dr. Custer is board certified in pediatrics, with board certified sub-specialization in neonatology and critical care medicine. The other doctors were also board certified in pediatrics, with subspecialties; one student was a resident rotating through the pediatric intensive care unit, and another doctor was a resident in pediatrics. **(Ex S, 3/31/00 Hearing Trns, p 9)**. The court found that Dr. Casamassima was also board certified in pediatrics, and that the affidavits of merit met the requirements of MCL 600.2169 (1), stating:

> "The plain language of the statute indicates that specializations are to be taken into consideration but does not mention sub-specializations. As the defendant doctors and Dr. [Casamassima] share a board certified specialization in pediatrics, the affidavit of merit is signed by a health profession who plaintiff's attorney reasonably believes meets the appropriate requirements, therefore summary disposition is inappropriate and defendant's motion is denied." **(Ex S, 3/31/00 Trns, p 12)**.

Subsequently, Drs. Lipscomb, Nypaver, and Riskalla, were dismissed upon stipulation by the parties without prejudice, and are not parties to this appeal.

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9-14-01 Motion to Strike Plaintiffs' Expert

In August 2001, Dr. Custer filed a motion for summary disposition under MCR 2.116(C)(10), asserting that since plaintiffs' expert could not identify the individual agent, doctor or employee who caused the fractures of Austin's legs, the doctor could not testify as to the appropriate standard of care and summary disposition should be granted. Both defendants jointly moved to strike Dr. Casamassima as an expert, asserting that he was unqualified under MCL 600.2169[7]. In addition, both defendants also moved for partial summary disposition to strike portions of the plaintiffs' Complaint. On September 14, 2001 the motions were brought on for hearing. Ultimately the trial court granted the defendants' joint motion to strike Dr. Casamassima as an expert. Defendants argued that Dr. Custer and the employees of the medical center against whom plaintiffs brought their claims were practicing pediatric intensive care medicine. Defendants asserted that since plaintiffs' board certified pediatrician, Dr. Casamassima, did not practice in the sub-specialty of intensive care medicine, that he was not qualified to give expert testimony in these matters. **(Ex T, 9/14/01 Hearing Trns, pp 14-16)**.

In response, plaintiffs argued that Dr. Casamassima was qualified in pediatric care, the area in which plaintiffs assert the malpractice occurred, that the statute did not require a subspecialty match. In addition it was argued expert testimony might not be necessary under the facts and circumstances of the case in light of the doctrine of *res ipsa loquitur* and Dr. Custer's admission. **(Ex T, 9/14/01 Hearing Trns, pp 18-23)**. Since this is a case where an otherwise healthy 15-day

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[7] In light of its ruling striking plaintiffs' expert, the court did not render an opinion on the substance of defendants' motions for summary and partial summary disposition, which were also scheduled for argument. **(9/14/01 Hearing Trns, pp 29-32)**. Also, plaintiffs conceded to dismissal of Johanna and Steven Woodard's claims for negligent infliction of emotional distress.

old infant with a respiratory virus sustains two broken legs while under the care and control of the defendants, plaintiffs were entitled to proceed even without expert testimony under the *res ipsa loquitur* doctrine. **(Ex T, 9/14/01 Trns, pp 18-21)**.

The court opined that per the deposition testimony of Dr. Casamassima:

> "One, between December 1993 and March of 1998, none of his clinical practice involved pediatric critical care medicine; two, he has no experience or training as an attending physician in a pediatric intensive care unit; three, he has no specialty training in pediatric hematology, pediatric infectious diseases; four, the last time he inserted a central venous line in, performed an intubation on, or inserted a central arterial line in a 15 month old infant was during his residency in the early 1980's; five, he became a full-time lawyer in March of 1998; and six, his pediatric practice contains approximately two days per week in the context of a home for mentally disabled children, in which arena he performs no work as the attending physician responsible for the patient's care.
>
> Considering this testimony, this Court finds that Dr. [Casamassima] did not devote a majority of his time within the year preceding the injury to the same active clinical speciality as Dr. Custer or the staff of the pediatric intensive care unit. Dr. [Casamassima] admitted that he had no experience with pediatric critical care within one year prior to the injury complained of." **(Ex T, 9/14/01 Trns, pp 30-31)**. (Emphasis added).

In finding that plaintiffs' expert was not qualified under MCL 600.2169, and plaintiffs therefore having no expert testimony to support their claims, the court dismissed plaintiffs' complaints. **(Ex T, 9/14/01 Hearing Trns, p 32)**. The court did not give an opinion on whether plaintiffs' action fell into one of the exceptions (such as *res ipsa loquitur*) whereby such expert testimony is not necessary. Plaintiffs' counsel orally moved the Court for an extension of time to secure a new expert, which the court denied, stating that issue was not properly before the Court on a motion. **(Ex T, 9/14/01 Hearing Trns, pp 32-33)**. Plaintiffs then filed motions for a determination on the necessity of an expert; for an extension to secure another expert; and to amend the Complaints to invoke *res ipsa loquitur*.

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10-12-01 Motions

On October 12, 2001, hearing took place on plaintiffs' motion for a determination by the court that dismissal of plaintiffs' causes of action were not required since plaintiffs' cases fell under one or more exceptions to the general rule requiring expert testimony in professional malpractice, or in the alternative, for an extension of time to secure a pediatric expert with sub-specialization in critical care medicine in substitution for Dr. Casamassima. The motion to amend the complaints to both dispense with some of its allegations on breaches of the standard of care and to invoke the doctrine of *res ipsa loquitur,* were also heard. **(Ex V, 10/12/01 Hearing Trns).** Plaintiffs' proposed amended (consolidated) complaint alleged the elements of *res ipsa loquitur*, and breaches of the standard of care as to the positioning or performance of line insertions and/or other maneuvers upon Austin so as to cause his fractured femurs. **(Ex U, amended complaint)**.

Plaintiffs further argued since defendants injured portions of Austin's body which were free of disease and not designated for treatment, under Michigan case law and the doctrine of *res ipsa loquitur*, no expert testimony was necessary. **(Ex V, 10/12/01 Hearing Trns, pp 4-13)**. In addition, it was argued if the court determined expert testimony was necessary, then plaintiffs could elicit the expert testimony upon cross-examination of Dr. Custer as to the standard of care and breach thereof. Indeed Dr. Custer had already given that testimony. **(Ex V, 10/12/01 Hearing Trns, pp 12-13)**. Defendants asserted plaintiffs needed expert testimony to establish breaches of the standard of care, and since the court struck plaintiffs' only expert, that the cases should be dismissed. **(Ex V, 10/12/01 Hearing Trns, pp 16-20)**.[8] The court took the motions under advisement. (Id. p 25).

[8]Also up for hearing was defendants' motion to enter the dismissal order based on the September 14 bench ruling.

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By written order and opinion dated February 7, 2002, the trial court denied plaintiffs' motion to amend their complaint to specifically invoke the doctrine of *res ipsa loquitur*, finding that "irrespective of whether justice requires this Court to permit amendment, the amendment requested is futile absent medical testimony to support the causes pled." **(Ex W, 2/7/02 opinion and order, p 5)**. The court found that expert testimony would still be necessary, even when using *res ipsa loquitur*, in considering whether Austin's fractures could have occurred in the absence of someone's negligence. **(Ex W, 2/7/02 opinion and order, pp 5-6)**. The court also denied plaintiffs' request in the interest of fairness for an extension of time to substitute its expert, based upon the fact defendants challenged plaintiffs' affidavit of merit early in the proceedings, and since the scheduled trial date was two months away. **(Ex W, 2/7/01 opinion and order, p 6)**. The order dismissed plaintiffs' complaints with prejudice. **(Ex W, 2/7/01 opinion and order, pp 6-7)**.[9]

RULINGS AND PROCEEDINGS IN THE COURT OF APPEALS

Plaintiffs appealed the trial court's dismissal of their case to the Court of Appeals as a matter of right. The Court of Appeals reinstated plaintiff's claim for *res ipsa loquitur* with Judge Talbot dissenting. The Court of Appeals, with Judge Borrello dissenting, ruled that although Dr. Casamassima was board certified in pediatric medicine, he did not match up in the subspecialty of pediatric critical care medicine, and hence, precluded plaintiffs from using him as an expert. Defendants have applied for leave on the *res ipsa* issues. Plaintiffs now apply for leave on the experts' qualifications issue.

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[9]The trial court also preemptively denied plaintiffs a motion for reconsideration **(Ex W, p 2, fn 1)**; however, the reference by the court to such a motion is incorrect; plaintiffs in their motion to amend had mentioned in a footnote they "intended" on filing for reconsideration of the court's ruling striking their expert. No motion for reconsideration had yet been filed; with the trial court's preemptive ruling, it became futile.

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ARGUMENT

WHERE PLAINTIFFS' EXPERT IS BOARD CERTIFIED IN PEDIATRIC MEDICINE AND THE DEFENDANT HOSPITAL'S DOCTORS IN THE PEDIATRIC UNIT WERE EITHER BOARD CERTIFIED IN PEDIATRIC MEDICINE OR SPECIALIZING IN PEDIATRIC MEDICINE WITH SUBSPECIALTIES, AND THE INFANT PLAINTIFF WAS INJURED DURING PEDIATRIC PROCEDURES, THE COURT OF APPEALS ERRED IN UPHOLDING THE TRIAL COURT'S STRIKING PLAINTIFFS' EXPERT AND DISMISSING THE SUITS FOR LACK OF AN EXACT MATCH TO THE REMAINING DEFENDANT DOCTOR'S SUBSPECIALTY.

The standard of review on grant or denial of a motion for summary disposition is *de novo*. Fane v Detroit Library Comm'n, 465 Mich 68, 74 (2001). In reviewing motions for summary disposition under MCR 2.116(C)(7) and (10), the court considers pleadings, affidavits, depositions and other documentary evidence submitted by the parties in the light most favorable to the party opposing the motion. Tate v Detroit Receiving Hospital, 249 Mich App 212, 215 (2002). Here, defendants argued Dr. Casamassima was not qualified under MCL 600.2169 and, being plaintiffs' only expert, striking him would mandate dismissal of the cases. Presumably defendants were seeking a summary disposition under MCR 2.116(C)(7), as well as (C)(10), although their motion to strike did not invoke (C)(7).

Statutory construction involves questions of law which are reviewed *de novo*. Tate, supra. Whether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony are within the trial court's discretion. Such decisions are reviewed for abuse of discretion. Tate, supra.

Like the defendants in Tate, defendants here argued that MCL 600.2169 required that the opposing parties' medical expert be certified in each of the subspecialties as those of the defendants in order to qualify as an expert. Contrary to The Court of Appeals ruling in Tate, Judge Talbot and

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Judge Meter agreed with the trial court when the trial court required the plaintiffs' expert to be not only be board certified in Pediatrics, but also practice in the subspecialty of critical care. They ignored that, as a practical matter, Dr. Casamassima had performed all of the procedures done by the medical staff during the course of his residency program. (Ex P, Casamassima, pp 99, 100). More to the point, the statute does not require such subspecialty matching. MCL 600.2169 provides as follows:

> "Sec. 2169. (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care **unless the person is licensed as a health professional in this state or another state and meets the following criteria**:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same speciality as the testimony is offered. **However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that speciality**.
>
> (b) Subject to subdivision (c), during **the year immediately preceding the date of the occurrence that is the basis for the claim or action**, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, **the active clinical practice of that speciality**.
>
> (ii) The **instruction of students** in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, **an accredited health professional school or accredited residency or clinical research program in the same speciality**." MCL 600.2169. (Emphasis added).

The Court of Appeals, by requiring Dr. Casamassima to be qualified in the subspecialties of the PICU doctors because he was not practicing the subspecialty of critical care medicine has,

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created an impossible standard. (See p. 6, exhibit 2). However as stated by the Tate court:

> "Certainly §2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a perfect match would be an onerous task and in many cases make it virtually impossible to bring a medical malpractice case. Surely the Legislature did not intend to eradicate a plaintiff's ability to bring a meritorious malpractice action against the defendant physician who happens to have board certifications in several different fields. However, this eventuality is exactly what the trial court and defense counsel suggest is permissible under §2169." (Tate at 219).
>
> * * *
>
> To further restrict the statute based on the trial court's logic would render an absurd result. Thus, where a defendant physician has several board certifications and the alleged malpractice only involves one of these specialties, §2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice." (Tate at 220).

By way of example on why requiring perfect matches is absurd, the court noted the following example: "If a physician who is board certified in both gynecology and emergency medicine incorrectly sets a broken leg in the emergency room, the case would clearly be within the purview of emergency medicine. Thus, any malpractice in that case would concern the physician's specialty in emergency medicine and would have nothing to do with gynecology." Tate at 219 fn 1. Here, plaintiffs' theory is the fractures of Austin's legs occurred during **general pediatric maneuvers**. The injuries he received were not of the variety requiring that any of the hospital's physicians call upon a subspecialty of critical care medicine, intensive care, hematology or infectious diseases. The evidence supports that the broken legs occurred because of misapplied force or mishandling during pediatric maneuvers. As stated in Tate, "Allowing the defense to assert that either critical care or neuphrology were involved in the alleged malpractice would effectively negate plaintiff's theory of the malpractice and thereby render plaintiff's expert unqualified under §2169. **We do not find that**

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§2169 exists to allow defendants in a malpractice case the opportunity to dictate a plaintiff's theory of the alleged malpractice." (Emphasis added). Tate at 220. While the trial court did not have the benefit of the Tate decision which was rendered January 16, 2002, plaintiffs did in fact argue that the statute did not require an exact match of subspecialties. Indeed, the trial court at the earlier hearing of March 31, 2000, acknowledged that the plain language of the statute did not mention subspecializations. At that hearing the court ruled that where the defendant doctors and Dr. Casamassima share board certified specializations in pediatrics, the language of the statute was met. **(Ex S, 3/31/00 Trns, p 12).**

Dr. Casamassima testified at his deposition as to those procedures which could have caused the femur fractures; identifying positioning during insertion of the femoral venous line, positioning during the insertion of the femoral arterial line, positioning during intubation, performance of Barlow's maneuver and performance of Ortolani's maneuver. **(Ex P, Casamassima dep pp. 10-11)**. Dr. Casamassima described how these maneuvers are performed (Id. pp. 11-17). In addition, the infant would have to have been repositioned or moved to prevent skin breakdown, DVT and line occlusions. (Id. p. 34)In spite of the defendant failure to present any testimony these maneuvers are unique to "critical care" as opposed to general pediatric care, the Court of Appeals concluded this action involved pediatric critical(intensive) care. (See p. 5, Exhibit 2). The defendants would prefer the court to focus on intubation, arterial line placement, femoral line placement and IV's, all while attempting to imply that these are unique to critical care. However, the defendants also stated that these procedures were performed by Dr. Casamassima during residency and during his earlier years of practicing pediatric medicine. They can't have it both ways. Certainly, if these are tasks a resident performs during residency, they cannot be characterized as unique to critical care. Again,

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it is not those procedures; rather the positioning or maneuvering of the infant which plaintiffs contend was negligently performed. A 15-day old infant simply should not suffer two broken femurs while being treated for a respiratory problem. This case concerns malpractice in general pediatric maneuvers, ie. the handling of the infant; not critical care malpractice.

Defendants argue that the Tate case holds that if an injury occurs within the confines of a particular unit, that the speciality of medicine being practiced in that unit is the controlling speciality. This is not at all what Tate holds. Tate clearly held that MCL 600.2169 does not require an exact match of every board certification of the defendants. Tate at 219. The court concluded that to require such a match was absurd and would lead to an eradication of a plaintiff's ability to bring a meritorious malpractice action. Id. Like the trial court, the Court of Appeals concluded that since Austin was in the critical care unit, plaintiffs' expert must have a speciality in critical care medicine matching that of the doctors in the unit. Defendants have extrapolated the analysis in Tate far beyond the confines of the issue in Tate. The issue in Tate was whether there had to be an exact of sub-specialities when the statute did not mention sub- specialities; only board certification in the speciality at issue. Id. at 220.

The Court of Appeals also ruled that Dr. Casamassima was not qualified based on his background since he was not practicing critical care medicine (see page 6, Ex 2). The Court of Appeals did not view the evidence in the light most favorable to plaintiffs, the non-moving party. Tate at 215.

The issue is by no means new to this Court since the exact issue is now before this Court as it has been extensively briefed, and orally argued, in the case of Rebecca Grossman v Otto Brown, M.D., et al., Supreme Court Docket No. 122458. As this Court is well aware from plaintiff's brief

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to the Court in that case, extensive information was provided demonstrating there are only 24 actual boards of certification. (See Grossman, plaintiff's brief page 8). Further, in Grossman the plaintiff established that to obtain a certificate in a subspecialty, all that is really necessary is to attend the fellowship, submit a list of procedures and in some situations taking additional testing, but this is not board certification. The point is, the Court of Appeals here was wrong in assuming there is board certification of subspecialties.

STATUTORY CONSTRUCTION

This Court has repeatedly emphasized it is the function of the judiciary to strictly construe Michigan statutory law and the statute will be enforced as written. In the case of Robinson v The City of Detroit, 462 Mich 439, 472-473 (2000), Judge Corrigan articulated the function of the judiciary and the limitations on its powers.

> To preserve the legitimacy of the judicial branch, this Court must not exceed the limits of its constitutional authority. I agree that too rapid change in the law threatens judicial legitimacy, as it threatens the stability of any institution. But the act of correcting past rulings that usurp power properly belongs to the legislative branch does not threaten legitimacy. Rather, it restores legitimacy. Simply put, our duty to act within our constitutional grant of authority is paramount. If a prior decision of this Court reflects an abuse of judicial power at the expense of legislative authority, a failure to recognize and correct that excess, even if done in the name of stare decisis, would perpetuate an unacceptable abuse of judicial power.

In Robertson v Daimler Chrysler Corp., 465 Mich 732, 748 (2002), this Court again stated, "The Legislature is presumed to have intended the meaning it has plainly expressed, and if the expressed language is clear, judicial construction is not permitted and the statute must be enforced as written." Words in a statute are not to be ignored, treated as surplusage or rendered nugatory. Id.

It is difficult to imagine how under Section 2169, this Court could interpret, in light of past

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rulings, that the statutory language requires that there be a matching of subspecialties. The Legislature clearly set forth an intent that the expert only match the Board Certified specialty of the defendant or defendants, not subspecialties. The Court of Appeals and the trial court cleared erred in requiring an exact match of subspecialties.

RELIEF REQUESTED

For the reasons stated above, this Court is requested to grant the Application for Leave to Appeal; reverse the Court of Appeals ruling upholding the trial court's February 7, 2002 order dismissing the case and disqualifying plaintiffs' expert; and rule plaintiffs' expert is qualified. Further this Court is requested to remand this case for trial.

Respectfully submitted,

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